

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034193

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar No.

STATE FILE NUMBER

FILED AUG 22 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

admission)

OR TOWN

c. FULL NAME OF (If NOT in hospital, give location)

Inside Limits

c. CITY OR TOWN

(If outside, give location)

Inside Limits

Yes ☐ No ☐

Reside on Farm

Yes ☐ No ☐

## 3. NAME OF DECEASED

(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

## 5. SEX

## 6. COLOR OR RACE

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

## 8. DATE OF BIRTH

## 9. AGE (last birthday)

## IF UNDER 1 YEAR

## IF UNDER 24 HR

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (City and state or country)

## 12. CITIZEN OF WHAT COUNTRY

## 13a. FATHER'S NAME

## 13b. MOTHER'S MAIDEN NAME

## 14. NAME OF HUSBAND OR WIFE

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES

(Yes, no, or unknown) (If yes, give war or dates of service)

NO.

## 17. INFORMANT

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Cardiac Decompensation.

## INTERVAL BETWEEN ONSET AND DEATH

## DUE TO (b)

Myocarditis.

1yr. 3month

## DUE TO (c)

Acute Nephritis.

422.2

6 days.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

## 20a. ACCIDENT SUICIDE HOMICIDE

☐☐☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

21. I attended the deceased from Jan. 5th. 1962 to Aug. 16th. 1963 and last saw him alive on Aug. 16th., 1963.

Death occurred at 11:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

D.C.

## 22b. ADDRESS

3407 S. Grand Blvd.,

## 22c. DATE SIGNED

8-17-63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE

## 23c. NAME OF CEMETERY OR CREMATORY

## 23d. LOCATION (City, town, or county)

(State)

REMOVAL

AUG. 29, 1963

SUNSET BURIAL PARK

ST. LOUIS CO.,

MO.

## 24. FUNERAL DIRECTOR

## ADDRESS

## 25. DATE RECD. BY LOCAL REG.

## 26. REGISTRAR'S SIGNATURE

Thomas Kutia 2906 Gravois

8-19-1963

Road Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

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USE BLACK INK

OR

TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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Dr. Wm. Deethrick  
3407 So Grand  
Rt 16861

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.